DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2000-09

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 3,151
b. FFY 2001 $ 12,625

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Exhibit I

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Exhibit I

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Reimbursement (Version VIII)

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Currently in review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bob Sharpe

14. TITLE:
Acting Deputy Director

15. DATE SUBMITTED:
September 15, 2000

16. RETURN TO:
Mr. Bob Sharpe
Acting Deputy Director for Medicaid
Agency for Health Care Administration
Post Office Box 12600
Tallahassee, Florida 32317-2600

Attention: Wendy Johnston

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 19, 2000

18. DATE APPROVED:
April 5, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Cranmer

22. TITLE:
Associate Regional Administrator
Division of Medicaid & State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

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FLORIDA TITLE XIX OUTPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION VIII

EFFECTIVE DATE: September 20, 2000

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 5 calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete, legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year, making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual (HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, Florida Administrative Code (F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new hospital or a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim rate shall be the lesser of: the county reimbursement ceiling for variable costs

(including outpatient fixed costs); or the budgeted rate in compliance with HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. and Section III of the Plan, as applied to the budget submitted by the provider. Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA)except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 Code of Federal Regulations (CFR) 413.35-413.50 (1998), and further interpreted by the Provider Reimbursement Manual (HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C.). and as further modified by this plan.

E. Hospitals shall file a legible and complete cost report within 5 months, or 6 months if a certified report is being filed, after the close of its reporting period. Medicare-granted exceptions to these time limits shall be accepted by AHCA.

F. If a provider submits a cost report late, after the 5 month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 5 months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be affected retroactively. Medicare granted exceptions to these time limits shall be accepted by AHCA.

G. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final

cost report is not required when: the capital stock of a corporation is sold; or partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged. Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

H. All Medicaid participating hospitals are required to maintain the Florida Medicaid Log and financial and statistical records regarding outpatients in accordance with 42 CFR 413.24(a)-(c)(1998). For purposes of this plan, statistical records shall include the medical records of eligible Medicaid recipients. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). A Medicaid recipient's medical records shall be released to the above named persons for audit purposes upon proof of the recipient's consent such as the Medicaid consent form, AHCA-Med Form 1005 as incorporated by reference in Rule 59G-1.002 (13), F.A.C.

I. Records of related organizations as defined by 42 CFR 413.17 (1998) shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

J. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 45 CFR 205.60 (1997). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the party making the request and the information requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor 15 days from receipt of the request by AHCA.

II. Audits

A. Background

A hospital common audit program has been established to reduce the cost of auditing submitted cost reports and avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital which shall serve the needs of all governmental programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII, and XIX. Under this agreement, the intermediaries shall provide AHCA the result of desk reviews and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits. AHCA shall:

1. Determine the scope and format for on-site audits;
2. Desk audit all cost reports within 6 months after their submission to AHCA;
3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 (10/94) F.A.C.
4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.160 F.A.C..

5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required.

6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA as incorporated by reference in Rule 61H1-20.008 (10/94), F.A.C. and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60 (1997).

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audits using prior approved State plans shall be reimbursable to AHCA, as shall overpayments attributable to unallowable costs only.

2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely, overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of desk or field audits of outpatient hospital services shall be identified separately from the results of desk or field audits of inpatient hospital services.

4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.

5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.

6. The terms of repayments shall be in accordance with Section 414.41 , Florida Statutes.

7. All overpayments shall be reported by AHCA to HHS as required.

8. Information intentionally misrepresented by a hospital in the cost report shall result in a suspension of the outpatient hospital from the Florida Medicaid Program.

F. Appeals

For audits conducted by AHCA a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Rule 59-1.018(4), F.A.C., and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.35-413.50 (1998), the inpatient routine nursing salary cost differential, and the guidelines in the Provider Reimbursement Manual (HCFA PUB. 15-1 as incorporated by reference in Rule 59G-6.010, F.A.C., and as further modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 (1998)and 42 CFR 440.140 (1998) in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;

2. The requirements established by the State Agency responsible for establishing and maintaining health standards under the authority of 42 CFR 431.610 (1998); and

3. Any other requirements for licensing under the State law which are necessary for providing inpatient hospital services.

B. Medicaid reimbursements shall be limited to an amount, if any, by which the rate calculation for an allowable claim exceeds the amount of a third party recovery during the Medicaid benefit period. In addition, the reimbursement shall not exceed the amount according to 42 CFR 447.321 (1998).

C. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Outpatient costs to Total Hospital Costs.

D. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for covered services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from Medicaid recipients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid bad debts generated by Medicaid recipients. Bad debts shall not be considered as an allowable expense.

E. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by the Agency or the Agency's authorized representative.

F. Surgical procedures identified by AHCA in Appendix E of the Hospital Coverage and Limitations Handbook as incorporated by reference in Rule 59G-4.150, F.A.C. shall require prior authorization if stipulated by Rule 59G-4.150, F.A.C. Failure to meet the requirements shall result in the disallowance of such charges associated with the surgical procedures. Appropriate adjustments shall be made to the Florida Medicaid Log.

G. Certain revenue centers are not reimbursed by Medicaid. Service rendered under these centers shall not be recorded on the Medicaid log and shall not be billed to Medicaid. The list of covered revenue centers is attached as Appendix A. Modifications of this list subsequent to the implementation of this plan shall appear in the Florida Medicaid Information System Update.

H. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.101, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

IV. Standards

A. In accordance with Chapter 120, F.S., Administrative Procedures Act, and 42 CFR 447.205 (1998), this plan shall be promulgated as an Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. Reimbursement ceilings shall be established prospectively for each Florida county. Beginning with the July 1, 1993 rate period, additional ceilings based on the Target Rate System shall also be imposed. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized, rural, or as a Community Hospital Education Program (CHEP) hospital. Outpatient reimbursement ceilings shall be established for and applied to general hospitals. Rural and specialized psychiatric hospitals shall be excluded from the calculation and application of the outpatient reimbursement ceilings. Statutory teaching, other specialized, and CHEP hospitals shall be included in the calculation but are exempt from the application of the outpatient reimbursement ceilings. .

C. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods, the reimbursement ceilings shall be effective from January l through June 30 and July l through December 31 of the appropriate years except as provided in G. below.

D. Changes in individual hospital rates shall be effective from July l, through December 31 and January l through June 30 of each year.

E. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. In the absence of sufficient information from the above source, claims payment data from the Medicaid fiscal agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

F. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings-

G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.

2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date the rate was established, or if the change is not material.

3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.

4. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

H. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 28-106, F.A.C., and Section 120.57 Florida Statutes.

I. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established, except as provided for in IV B.

J. In accordance with Section 2302 of Public Law 98-369, the Deficit Reduction Act of 1984, the reimbursement rates for laboratory and pathology services shall be the lower of: the hospital's charges or; the Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:

   a. To reflect the results of desk or field audits.

   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9 (1998).

3. Determine Medicaid outpatient variable costs defined in Section X.

4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and either September 30,

or March 31, the midpoint of the rate semester for which the new rate is being calculated. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.

5. Divide the inflated Medicaid outpatient variable costs by the latest available Health, Recreation and Personal Services component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.

6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.

7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

   a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling. Teaching, other specialized, and Community Health Education (CHEP) hospitals are included in the calculation but are exempt from the application of this cost based ceiling.. For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

b. For rate periods beginning with the July 1,1993 rate period, the target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

$$1 + 1.4 \times \left[\frac{\text{Midpoint of the prospective rate period using appendix B}}{\text{Midpoint of the current rate period Using Appendix B}} - 1 \right]$$

This target ceiling shall not apply to rural, specialized ,statutory teaching and Community Hospital Education Program (CHEP) hospitals.

B. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report as follows:
   a. To reflect the results of desk and field audits.
   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1998).
3. Determine Medicaid outpatient variable costs as defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.
5. Establish the variable cost rate as the lower of:

a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.

b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings. This target rate shall not apply to rural, specializd, statutory teaching, or Community Hospital Education Program (CHEP) hospitals.

6. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX Outpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204 (1998).